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No. 90-162

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1990

ROCKFORD MEMORIAL CORPORATION AND SWEDISHAMERICAN CORPORATION,

Petitioners,

v.

UNITED STATES OF AMERICA,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF OF *AMICUS CURIAE* AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES.....	ii
BRIEF OF THE AMERICAN MEDICAL ASSOCIATION	1
Question Presented.....	2
Interest of the Amicus Curiae	3
Statement of the Case	6
ARGUMENT.....	33
The Proposed Merger is a Pro-Competitive Adaptation to the Adverse Trends in the Hospital Industry.....	33
CONCLUSION.....	41

TABLE OF AUTHORITIES

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Brown Shoe v. United States,
370 U.S. 294 (1962)..... 43

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Board of Governors of Federal
Reserve System,845 F.2d 1035
(D.C. Cir. 1988)..... 44

Robinson v. Magovern, 521 F.
Supp. 842 (W.D. Pa. 1981),
aff'd, 688 F.2d 824
(3rd Cir. 1982), cert. denied,
459 U.S. 971 (1982)..... 12, 28-9

Tampa Electric Co. v.
Nashville Coal Co.,
365 U.S. 320 (1961)..... 41

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Hughes Inc., 1990 - 1 Trade
Cas. (CCH) ¶ 69,084
(D.C. Cir. July 6, 1990)..... 42, 43

United States v. Connecticut
National Bank, 418 U.S. 656
(1974)..... 42

United States v. Country Lake
Foods, Inc., 1990-2 Trade Cas.
(CCH) ¶ 69,113 (D Minn.
June 1, 1990)..... 41

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United States v. First National Bank of Jackson, 301 F. Supp. 1161 (S.D. Miss. 1969)..... 44

United States v. General Dynamics Corporation, 415 U.S. 486 (1973)..... 42,43

United States v. Idaho First National Bank, 315 F. Supp. 261 (D. Idaho 1970)..... 44

United States v. Philadelphia National Bank, 374 U.S. 321 (1963)..... 42

STATUTE:

Ill. Rev. Stat. ch. 111 1/2, para. 5604 (1987)..... 25

REGULATION:

52 Fed. Reg. 10, 935 (1987)..... 21

ARTICLES:

Abdo, Veterans on The Attack: Better Complaints on VA Hospital Care, Newsday (May 16, 1989) at 31..... 31

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Boland, Specialties Can Be a Business Tool, Modern Healthcare (July 1, 1988) at 26..... 21

Burda, Why Hospitals Close, Modern Healthcare (March 24, 1989) at 24..... 8, 13

Coddington, Palmquist, and Trollinger, Strategies for Survival in the Hospital Industry, Harv. B. Rev. (May/June 1985) at 129..... 6, 14, 18

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Dyer, Hospitals Saw Patient Margin Vanish in 1988, Hospitals (May 5, 1989) at 58..... 7

Effects of Surgeon Volume and Hospital Volume on Quality of Care in Hospitals, Medical Care (June 1987) at 489..... 20

Gabel and Schramm, Prospective Payment: Some Retroactive Observations, The New Eng. J. of Med. (June 23, 1988) at 1681-2..... 18, 19

Gleicher and Meyers, A Successful Program to Lower Cesarean Section Rates, The New Eng. J. of Med. (December 8, 1988) at 1511..... 17

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Larkin, Pressure Builds, But Will Regulation Result?, Hospitals (March 5, 1990) at 29..... 14

Luft, Garnick, Mark, Peltzman, Phibbs, Lichtenberg and McPhee, Does Quality Influence Choice of Hospital?, J. A.M.A. (June 6, 1990) at 2899, 2905..... 24, 25

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Sattler, For Good Health Care, Fend for Yourself, Wall Street Journal (June 5, 1989)..... 32

Solovy, Endurance is Key to Successful Turnaround, Hospitals (February 20, 1989) at 70..... 12

Tokarski, HCFA Issues Mortality Data, Modern Healthcare (December 23, 1988) at 2..... 25

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BRIEF OF AMICUS CURIAE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

The American Medical Association ("AMA") respectfully submits this brief

as amicus curiae in support of the petitioners. The written consents of petitioners, Rockford Memorial Corporation and SwedishAmerican Corporation, and of respondent, United States of America, are on file with the Clerk of the Court.

QUESTION PRESENTED

The AMA will address the following question as amicus curiae: Whether the district court erred in defining the geographic market and assessing the+ future impact on competition by failing to consider the extraordinarily rapid changes in the hospital industry, which are transforming the existing hospital products and usage patterns and creating entrepreneurial opportunities for hospitals with the foresight and

resources to engage in regional competition.

INTEREST OF THE AMICUS CURIAE

The AMA is the nation's largest medical association. Its membership includes more than 250,000 physicians and medical students. It is dedicated to protecting the public welfare by maintaining the highest professional standards and promoting quality medical care. The AMA has promoted the provision of high quality care by physicians through the use of high quality hospitals throughout its history. For example, the AMA is one of the five corporate members of the Joint Commission for Accreditation of Healthcare Organizations, which is the entity most relied upon by state governments, the

federal government, health insurers, and others to accredit hospitals.

The hospital industry is going through a period of rapid change due to compelling economic forces. The future shape of the industry is extremely important to physicians. It is physicians who perform or direct most of the patient care provided in a hospital.

Mergers are one of the vehicles through which the industry is transforming. Physicians have two interests at stake when a hospital merger is proposed. Physicians generally prefer to have more than one hospital available to ensure responsiveness. However, most will support a merger if they believe that it will result in a more cost effective institution that has

better facilities, equipment, and support services. The AMA is concerned that these interests, together with other important interests, be appropriately balanced as the antitrust law regulation of hospital mergers evolves.

The AMA is not prepared to state whether the proposed merger at issue should go forward. It is filing this brief because it believes that the court of appeals used an inappropriate methodology to evaluate the merger. By electing to preserve the status quo in a highly dynamic industry, the court may have interfered with a pro-competitive response to very compelling economic forces. The decision may leave patients, third party payers, and

physicians worse off than allowing creative entrepreneurial activity to be fostered through mergers, even if that activity appears to have some anticompetitive risks. The AMA believes that this case should be returned to the court of appeals for a more comprehensive appraisal of the pro-competitive potential of the merger in light of industry dynamics.

STATEMENT OF THE CASE

A. An Industry Shakeout Is Creating Opportunities For Effective Competitors

The revolutionary changes sweeping the hospital industry are occurring very quickly.[1/] These changes are forcing

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1/ Coddington, Palmquist, and Trollinger, Strategies for Survival in the Hospital Industry, Harv. Bus. Rev. (May/June 1985) at 129, 130.

a major shakeout in the industry. Reduced demand,[2] declining levels of reimbursement,[3] increasing operating costs,[4] and increasing capital costs associated with keeping up with rapidly improving new technology[5] have

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2/ See Touche Ross, U.S. Hospitals: The Future of Health Care - A Survey of U.S. Hospital Executives and Presidents of Medical Staffs on the Challenges They Face in an Environment of Enormous Change, (June 1988) at 4. See also Dyer, Hospitals Saw Patient Margin Vanish in 1988, Hospitals (May 5, 1989) at 58.

3/ Id. See also McCarthy, DRGs -- Five Years Later, The New Eng. J. of Med. (June 23, 1988) at 1683-4.

4/ See, e.g., Cole and Sizing, Cole Nurse Compensation Survey, Modern Healthcare (December 2, 1988) at 24.

5/ See, e.g., Wagner, Weighing the Cost of New Technology, Modern Healthcare (November 18, 1988) at 43.

financially weakened most hospitals and caused many to close.[6/] Some knowledgable observers predict that 40% of all hospitals will be closed or

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6/ Eighty-one hospitals closed in 1988. Burda, Why Hospitals Close, Modern Healthcare (March 24, 1989) at 24. At least 69 closed in 1987. Kusserow, Inspector General of the Health Care Financing Administration, Hospital Closure: 1987, OA1-04-89-00740 (May 1989) at (i). More than 200 community hospitals closed during the period 1980-1985. Rubin, Moran, Jones, Hackbarth, A Report by Lewin/ICF, A Division of Health Care and Sciences Research, Inc., to the National Committee for Quality Health Care, Washington, D.C., Critical Condition, America's Health Care in Jeopardy (1988) at 13.

converted to other uses by the year 2000.[7/]

The turbulence of a shakeout is a disaster for inefficient competitors, but it also creates unusual entrepreneurial opportunities for competitors with the foresight and resources to take advantage of them. That is the case in the hospital industry today. There are numerous marginally viable hospitals that are no longer competitive on the basis of quality and cost. It is possible for strong hospitals to attract patients away from

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7/ Rubin, supra, fn. 6, citing Gage, Andrulis, and Beers, America's Safety Net: A Report on the Situation in Our Nation's Metropolitan Areas, National Association of Public Hospitals (October 1987).

the marginal hospitals, especially by providing the most recent improvements in medical technology in a cost effective manner.

A report by the Inspector General of the Health Care Financing Administration about hospital closures in 1987[8/] provides insights into this competitive process. According to the report, competition with other hospitals was a factor in many of the closures. The report states that hospital viability is dependent on the stability of occupancy, revenue, and cost. When one element weakens, a chain reaction may begin which leads to closure. The chain

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8/ Kusserow, supra, fn. 6, at 7-11. See also McCarthy, supra, fn. 3 at 1684-5.

reaction usually starts with declining occupancy. That results in declining patient revenues, and higher fixed costs per patient day. Operating revenues no longer pay for the total cost of providing care.

To pay for operating expenses, the hospital diverts funds from capital reserves and defers maintenance, renovation of facilities, replacement of equipment, the purchase of equipment with improved technology, and the implementation of new services. Personnel are laid off and services cut to reduce costs. Soon the hospital is unable to compete with other hospitals. It is less attractive to physicians and patients, who start to go elsewhere. As the occupancy level continues to shrink,

fewer and fewer patients support the fixed costs. Operating revenues decline to the point that no funds are available and cannot be borrowed to make the investments necessary to compete for patients. As a result, the hospital's options are reduced to merger, sale or closure.

In the current environment, no hospital can assume that it is immune to the downward spiral. All hospitals have to compete vigorously for patients to be viable - inertia in responding to the competitive environment will not be forgiven.[9/] In evaluating why

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9/ Solovy, Endurance is Key to Successful Turnaround, Hospitals (February 20, 1989) at 70. See also Robinson v. Magovern, 521 F. Supp. 842, 860 (W.D. Pa. 1981)

hospitals closed during 1988, knowledgable observers said that hospital executives were not responsive to changes in their market.[10/]

The key to effective competition is making the investments necessary to deliver high quality services in a cost effective manner. In that regard, larger hospitals which have the resources to invest in quality and cost control mechanisms, and which can take advantage of economies of scale, clearly have an advantage over smaller institutions. "Hospitals with limited resources are hard-pressed to compete with newer or larger hospitals which aggressively market their services, maintain a

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10/ See Burda, supra, fn. 6 at 33.

healthy capital reserve, and offer high salaries to nursing and technical staff."[11/]

11/ Kusserow, supra, fn. 6 at 8; Larkin, Pressure Builds, But Will Regulation Result?, Hospitals (March 5, 1990) at 29. Many observers have suggested downsizing as a survival strategy for hospitals. See Coddington, supra, fn. 1 at 133. That involves scaling down the level of operations that can be carried out competently and profitably given a permanently reduced occupancy level. The strategy is much more difficult to execute than it might seem. Most hospitals are burdened with a physical plant designed for a larger scale of operations, and all of the support operations, such as laundry, laboratory, radiology and others, are designed for a larger scale of operations. It is difficult to "shrink" them. In addition, many operations, including the size of certain facilities, are required as a condition of state licensure and for accreditation by the Joint Commission

(footnote continued)

B. Hospital Competition is Becoming More Regional In Nature

It is common to assume, as the lower courts did in this case, that geographic hospital markets are local in nature, rarely larger than a metropolitan area, and that they will remain that way indefinitely. That assumption is based on (a) existing hospital usage patterns by patients, (b) the belief that physicians control where their patients are admitted for hospital services, and

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11/ (continued footnote)

for Accreditation of Hospitals. Downsizing is also risky because it means narrowing the range of support services available, and physicians do not like that. They may shift admissions elsewhere. In addition, patients may become leery of a hospital that is shrinking and becoming less capable. Kusserow, supra, fn. 6 at 8.

(c) the tendency for physicians to admit patients to hospitals nearby their offices, since the economics of medical practice make it impractical for physicians to use more distant hospitals.

The AMA believes that geographic hospital markets are growing, and that hospital competition is becoming regional in nature. The industry shakeout will result in fewer, more widely spaced hospitals which provide a higher level of service (tertiary care) than is the norm for community hospitals today (primary or secondary care). There are several reasons why.

First, a "third revolution" in medical care is causing the demand for hospital services to decline more. A tremendous effort to evaluate the

effectiveness and need for various medical procedures or treatments has begun. Preliminary indications are that a meaningful amount of care is of marginal benefit or even inappropriate. 12/ Existing excess hospital capacity will be exacerbated, and there will be a need for fewer hospitals.

Second, the need for hospitals to perform low levels of care is decreasing. Patients whose need for hospital care is questionable are now being kept out of the hospital -- these are

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12/ Relman, Assessment and Accountability: The Third Revolution in Medical Care, The New Eng. J. of Med. (November 3, 1988) at 1220; Gleicher and Meyers, A Successful Program to Lower Cesarean-Section Rates, The New Eng. J. of Med. (December 8, 1988) at 1511.

patients who are easy to care for and do not need a high level of services.[13/] In addition, other types of providers, such as outpatient surgery centers, ambulatory care centers, and outpatient rehabilitation centers are taking primary and secondary levels of care from hospitals.[14/] As a result, hospitals treat a more complex mix of patients today than they did in the early

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13/ Schramm and Gabel, Prospective Payment, Some Retrospective Observations, The New Eng. J. of Med. (June 23, 1988) at 1681-2.

14/ Schramm, supra, fn. 14 at 1682. That segment of hospital services, which no longer requires admission as an inpatient, is being sought after by an increasing number of other types of providers. See Multi-Unit Providers Survey, Modern Healthcare (June 2, 1989) at 64, 68, 72 and 78. Coddington, supra, fn. 1 at 131-2.

1980's.[15/] Hospitals will have to focus on the provision of higher level tertiary care services in the future. The hospital which concentrates on lower level primary - secondary care will be increasingly less viable.

The size of the investment necessary to provide high level tertiary care services continues to increase, especially the cost of acquiring the equipment and personnel necessary to provide the most recent improvements in medical technology.[16/] It is becoming increasingly difficult for most hospitals to keep up in this area.[17/]

15/ Schramm, supra, fn. 14 at 1682.

16/ See Wagner, supra, fn. 5.

17/ See McCarthy, supra, fn. 3 at 1684-5.

That will give hospitals which can find the resources to invest a competitive advantage.

Price competition and quality control measures implemented by third party payors will require that hospitals not only be able to provide high level services, but be able to do so as cost effectively as possible without sacrificing quality. Volume is necessary to assure optimum competence by providing sufficient experience to hospital personnel who perform a given service,[18/]

18/ See Effects of Surgeon Volume and Hospital Volume on Quality of Care in Hospitals, Medical Care (June 1987) at 489. See also Bennett, Garfinkle, Greenfield, Draper, Rogers, Mathews, and Kanouse, The Relation Between Hospital Experience and In-Hospital Mortality for Patients With AIDS-Related PCP, J. A.M.A. (May 26, 1989) at 2975.

and it is necessary to allow the economies of scale necessary to be cost effective.[19/]

These trends -- declining demand, the need to provide more expensive high levels of care, price competition, and the need for volume to provide high level services at a competitive quality

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19/ There is a trend for payors to seek discounts for high quality services by channeling high cost, high volume procedures to a select group of hospitals or "centers of excellence." The Health Care Financing Administration ("HCFA") limits the number of hospitals which may perform heart transplant operations on Medicare beneficiaries. 52 Fed. Reg. 10, 935 (1987); Tokarski, HCFA Targeting Coronary Costs in First Attempt to Pay for Procedures at a Discount, Modern Healthcare (December 16, 1988) at 16. For the activities of private payors, see Boland, Specialties Can Be A Business Tool, Modern Healthcare (July 1, 1988) at 26.

and cost, are forcing hospitals to expand the geographic area from which they draw patients. That generates regional competition. That is also where the opportunities are. A strong hospital that has a sufficient patient base and financial resources necessary to make the necessary investments can draw patients away from distant hospitals that do not have the resources to keep up. The serious competition will be between widely-spaced regional hospitals that are competing for the patients that are being lost by the smaller, less viable hospitals located between the regional hospitals.

The proximity of patients and physicians to a hospital will continue to be a factor in hospital competition, but it

will not be a bar to emerging regional competition. It will be possible for a hospital that is more competitive in quality and cost than distant hospitals to attract patients away from those hospitals. The decisive factor in such a contest are patient preferences for quality, cost, and an increasing degree of patient mobility. While patients and physicians value proximity, this is not the only factor that they consider.[20/] Patients are willing to

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20/ See Inguanzo and Harju, Creating a Market Niche, Hospitals (January 1, 1985) at 62, 64 for survey methodology. Further analyses appear in the following Hospitals issues: February 1, 1985 at 68; March 16, 1985 at 90; October 1, 1985 at 84; and November 1, 1985 at 91. The

(footnote continued)

travel to obtain services from physicians and hospitals that they perceive as being better than those nearby. Physicians are referring complex medical problems to hospitals which they perceive as possessing better quality facilities.[21/]

20/ (continued footnote)

survey concluded that: "Consumers are influenced by many factors when choosing a hospital. The most important factor could be quality of care, nearness to home, tradition, doctor's recommendation, cost, or a combination." Inguanzo and Harju, What Makes Consumers Select a Hospital?, Hospitals (March 16, 1985) at 90, 94; See also Robinson and Luft, Competition and the Cost of Hospital Care, 1972 to 1982, J. A.M.A. (June 19, 1987) at 3242.

21/ Luft, Garnick, Mark, Peltzman, Phibbs, Lichtenberg, and McPhee, Does Quality Influence Choice of Hospital? J. A.M.A. (June 6, 1990) at 2905.

Patients are increasingly aware of differences among hospitals, and therefore are capable of exercising judgment about which hospital to select. A substantial survey found that patients are aware that hospitals are not of equivalent quality, with different levels of technology and equipment, and with different costs and prices. Government agencies and private organizations are increasingly generating information that will help patients make choices.[22/]

22/ See Inguanzo, supra, fn. 21 (October 1, 1985) at 84; Tokarski, HCFA Issues Mortality Data, Modern Healthcare (December 23, 1988) at 2. Robinson, Sneak Preview: JCAHO's Quality Indicators, Hospitals (July 5, 1988) at 38; Ill. Rev. Stat. ch. 111 1/2, para. 5604 (1987). See also Luft, supra, fn. 22 at 2899.

According to the Inspector General's report on hospital closures, better informed patients do bypass local hospitals in favor of distant hospitals which are perceived as being of higher quality, and that has been a factor why some hospitals failed during 1987. The report says:[23/]

> Patients, too, preferred other hospitals.
>
> People are becoming better informed about health and medical care. They want the best care available, and they are more likely to question quality. Although they may be uncertain how to measure quality in technical terms, many will choose a large hospital over a small one; a newer, better equipped facility over one which shows its age. Many of the hospitals which closed in 1987 did not inspire patient confidence. . . .

23/ Kusserow, supra, fn. 6, at 8.

People are more mobile.

With better roads and improved transportation there is increased access to distant medical facilities. Now physicians and their patients can choose a hospital on the basis of quality or reputation rather than solely on proximity.

Strong regional hospitals will not be the only hospitals left, some small hospitals will survive, especially those that offer boutique or highly specialized service. However, the clear trend favors larger, regional competitors concentrating on the delivery of high level, high quality services at an effective cost.[24/] Most of the success

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24/ As Mr. Jeff Goldsmith, a national adviser on health care, recently stated: "However well hospitals meld their objectives and operations with those of their

(footnote continued)

stories in recent years involve hospitals that invested in expanding their geographic service area.[25/]

24/ (continued footnote)

doctors, however efficiently they use their work forces, and however conscious they become of delivering high-quality service, the fact remains that the facility as it has existed for generations is a dinosaur. It is too costly, too unwieldy in its single setting, and too inflexible. In the future, acute care will be concentrated in a small number of high-tech regional centers treating traumatic and chronically ill patients." Goldsmith, A Radical Prescription for Hospitals Harv. Bus. Rev. (May/June 1989) at 111.

25/ See Weinstein, Situation Analysis and Strategic Development in a Public Hospital, Hospitals & Health Services Administration (November/December 1986) at 62; Abelson, Hospitals Try to Staunch Patient Flow to Pennsylvania, Philadelphia Bus. J. (December 14, 1987) at 1013; Robinson v. Magovern, supra, fn. 9.

C. The Role of Price as Hospital Competition Becomes More Regional.

Research during the 1970's and early 1980's concluded that hospital costs and prices were higher in unconcentrated hospital markets than in concentrated ones.[26/] The assumed reason was that physicians and patients were not price sensitive, as third party payors generally paid for hospital care, and they

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26/ See, e.g., Robinson, fn. 21, at 3241; Farley, Competition Among Hospitals: Market Structure and its Relation to Utilization, Costs, and Financial Position, Research Note 7, Hospital Studies Program, DHHS Publication No. [PHS] 85-3353, U.S. Department of Health and Human Services, National Center for Health Services Research and Health Care Technology Assessment (1985); Noether, Competition Among Hospitals, Staff Report of the Bureau of Economics, Federal Trade Commission (1987).

selected hospitals primarily on the basis of quality. Therefore, hospitals competed by duplicating expensive services and overinvesting in facilities and equipment.

Recent research indicates that in California, where the state has pursued competition-based cost-containment policies, costs in competitive hospital markets have been declining in comparison with highly concentrated hospital markets.[27/] Therefore, price may be

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27/ See Melnick and Zwanziger, Hospital Behavior Under Competition and Cost Containment Policies, the California Experience, 1980-1985, J. A.M.A. (November 11, 1985) at 2669, and see Robinson and Luft, Competition, Regulation and Hospital Costs, 1982-1986, J. A.M.A. (November 11, 1988) at 2676.

becoming a more important factor in hospital competition.

A relevant question then becomes whether price competition will be localized in nature or regional in scope. Patients have shown that they will bypass local hospitals and travel to a distant hospital, the issue is whether patients will also travel for price.

There is no reason why patients will not travel for price if health benefit plans are structured to make it a factor in their selection of providers. 28/

28/ Inguanzo and Harju, Insurance Coverage Drives Consumer Behavior, Hospitals (November 1, 1985) at 91-2. Abdo, Veterans on the Attack: Bitter Complaints on VA Hospital Care, Newsday (May 16, 1989) at 31.

Certainly patients will place a value on proximity for which they will be willing to pay, just as consumers are willing to pay higher prices at a neighborhood drug store. But there is a limit to the value which is placed on convenience. When that value is exceeded, patients will travel.

In addition, payors are starting to make patients more price sensitive by making them share in the cost of care.[29/] Health care is expensive. Substantial penalties for use of more expensive nearby providers is likely to motivate travel.

29/ Sattler, For Good Health Care, Fend for Yourself, Wall Street Journal (June 5, 1989). See also FF. 52.

ARGUMENT

The Proposed Merger Is A Pro-Competitive Adaptation To The Adverse Trends In The Hospital Industry

The economic forces affecting Rockford Memorial Hospital (RMH) and Swedish American Hospital (SAH) are the same as those described in the previous sections of this brief. They face the same loss of viability as other hospitals, but they are also presented with the same opportunities if they take action now.

RMH and SAH are both solvent at the present time. However, there is obvious deterioration in the three elements which the Inspector General reports are necessary for hospital viability; stability of occupancy, revenue, and

cost.[30/] Both hospitals have very substantial excess capacity; RMH is operating at 75% of capacity and SAH is operating at 66%. [Trial Transcript ("Tr."). 1467, 1971-3]. Operating costs and capital costs necessary for replacement of equipment and acquisition of new medical technology are increasing. Sources of revenue are declining in comparison to costs -- Medicare and Medicaid account for about 50% of the hospitals' revenues, but pay less than the hospitals' costs of caring for the patients involved. [Finding of Fact

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30/ Kusserow, supra, fns. 6 and 8.

("FF.") 23].[31] Demand is also shifting away from primary-secondary care services towards higher level services.[32]

If SAH and RMH do not react, they could fall victim to the downward spiral described by the Inspector General.[33] Financial consultants

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31/ Those losses are in addition to the substantial cost that both hospitals incur for providing free care to indigent and uninsured patients who did not qualify for government assistance. RMH lost $3.2 million in charges during its fiscal year 1988 providing free care (Tr. 1453-4, FF. 24).

32/ The hospitals attribute the overall decline in demand to the efforts of third party payors to have as much care as possible taken out of the hospital and done on an outpatient basis or some alternative setting (Tr. 1617, 1627).

33/ Kusserow, supra, fns. 6 and 8.

hired by the hospitals before and after they agreed to merge, and their own internal studies, projected that they would incur substantial costs over the next five years if they did not respond to changing conditions (Tr. 1457, 1695, 1820).

However, these same economic forces have presented an opportunity to the hospitals. By merging, they can amass the resources and achieve the economies of scale necessary to become an effective regional competitor. The new entity would have the capital necessary to invest in providing higher level services, and their combined patient volume would allow them to provide high quality, high level services at an effective cost. It would then have a very solid

base upon which to attract patients away from distant hospitals and substantially expand its geographic drawing area.

The new hospital will be in a strong position to attract tertiary care patients who now go to regional competitors in Peoria, Chicago, Madison, Milwaukee, and the Quad cities (Tr. 90, 349, 1992, 2003, 2021). In addition, the new hospital would be able to compete with regional competitors for primary and secondary care patients who now go to smaller, less viable hospitals in the region. (Tr. 143, 1648, 2044). Many of the small hospitals surrounding Rockford are already operating at low

levels of occupancy.[34/] These hospitals do not have the resources or existing patient bases necessary to keep up with regional competitors -- there will be a contest for their patients as many become increasingly less viable.

Conversely, if RMH and SAH do not respond quickly to increase their regional market share, they are likely to weaken and become vulnerable to quality

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34/ For example, the 1988 edition of the American Hospital Association Guide to the Health Care Field (American Hospital Association) reports the following occupancy levels as of 1987 for the hospitals surrounding Rockford listed at FF. 118: Community General - 59.1%; Galena-Strauss - 63.5%; Harvard - N/A; Katherine Shaw - 54.5%; Morrison - 39.5%; Northern Illinois - 66.5%; Rochelle - 38.1%; Sandwich - 47.2%; Savannah - 20.6%; Mercy - 63.4%; St. Clare - 49.7%.

and price competition from distant regional competitors. Further, they can best take advantage of the competitive opportunity if they act now and do not wait until one or both is considered to be "financially ailing". Once ailing, the hospitals will have lost much of their capital resources and patient base necessary to create a strong regional competitor. At best, they will be able to achieve economies of scale in their remaining patient base to reduce costs that have become noncompetitive due to high per patient fixed costs.

In conclusion, the pro-competitive benefits to regional competition that the merged hospital would create are obvious. The benefit to physicians is also substantial -- it would create a

new entity capable of obtaining and providing the most recently available medical technology necessary to support their practices.

The emergence of regional price and quality competition should limit any risk of anticompetitive effects. There is no evidence that the intent of the merger is to reduce competition at a local level.

CONCLUSION

The court of appeals recognized that its geographic market did not strictly comply with the requirements of this Court in Tampa Electric Co. v. Nashville Coal Co., 365 U.S. 320 (1961).[35/] That deficiency was aggravated by the fact that the district court's and court of appeals' decisions in this case were based on a static view of the market as opposed to a full appraisal of the dynamic forces transforming the hospital industry. They relied in part on aging Supreme Court opinions which prohibited bank mergers using a similar static

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35/ Compare the lax approaches by the Rockford district court and court of appeals with United States v. Country Lake Foods, Inc., 1990-2 Trade Cas. (CCH) ¶ 69,113 (D. Minn. June 1, 1990).

analysis. See U.S. v. Philadelphia National Bank, 374 U.S. 321 (1963), and U.S. v. Connecticut National Bank, 418 U.S. 656 (1974). Subsequent events in the banking industry demonstrate that the results of these cases were inappropriate -- it is unlikely that they would be decided in the same way today. These cases demonstrate the weaknesses of the static approach in evaluating mergers and emphasize the importance of using the dynamic approach applied in U.S. v. General Dynamics Corp., 415 U.S. 486 (1973), and in U.S. v. Baker Hughes Inc., 1990-1 Trade Cas.

(CCH) ¶ 69,084, at 63,975 (D.C. Cir. July 6, 1990).[36/]

The bank merger cases relied on a cluster market theory and concluded that commercial banks did not compete with other offerors of financial services -- not even savings banks. Since those decisions, commercial banks have been intensively challenged by a wide variety of organizations, including savings

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36/ See General Dynamics, supra, at 498, citing Brown Shoe v. United States, 370 U.S. 294, 322 n.38 (1962). Baker Hughes reinforced General Dynamics' approach, contending that evidence on a variety of factors should be utilized in determining effects on competition.

banks, brokerage houses, investment bankers, and others.[37/]

The lower courts in this case assumed that existing patient usage patterns would remain the same, that distant hospitals could not attract

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37/ See The New York Times (April 8, 1989) at 33, col. 3 ("With deregulation, banks are now competing not only with savings institutions but with stock brokerage firms, insurance companies and retailers like Sears that offer financial services."); Irving Bank Corp. v. Board of Governors of Fed. Reserve Sys., 845 F.2d 1035, 1041 (D.C. Cir. 1988). See also United States v. Idaho First Nat'l. Bank, 315 F. Supp. 261, 267 (D. Idaho 1970); United States v. First Nat'l. Bank of Jackson, 301 F. Supp. 1161, 1179-1181 (S.D. Miss. 1969); United States v. Crocker-Anglo Nat'l. Bank, 277 F. Supp. 133, 153-61 (N.D. Calif. 1967). And see Note, The Line of Commerce for Commercial Bank Mergers: A Product-Oriented Redefinition, 96 Harv. L. Rev. 907, 908 (1983).

patients away from the Rockford hospitals, and generally did not appraise the trends leading towards regional competition. Failure to evaluate the dynamic forces at work may be a shortsighted and economically damaging effort to preserve the status quo. Therefore, this case should be returned to the court of appeals for an appropriate appraisal of the merger's pro-competitive potential.

Respectfully submitted,

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